

Child Intake

Child's name: _____ Date of birth: _____ Sex: M F Age: _____
 Date: _____ Referred by: _____ Weight: _____ Height: _____
 Who is filling out this form (name and relation)? _____
 Who does the child live with? _____

Contacts

Name: _____ Phone: _____ (home) _____ (work)
 Address: _____ Postal Code: _____
 Relationship to the child : _____

Name: _____ Phone: _____ (home) _____ (work)
 Address: _____
 Relationship to the child : _____

Other health care providers

Name: _____	Name: _____	Name: _____
Address: _____	Address: _____	Address: _____
Phone number: ()	Phone number: ()	Phone number: ()

Child's health concerns (in order of importance)

1. _____
2. _____
3. _____
4. _____
5. _____

Prenatal health

What was the health of the parents at conception?

Mother	Poor	Fair	Good	Excellent	Unknown
Father	Poor	Fair	Good	Excellent	Unknown

What was the physical health of the mother during the pregnancy?

Poor	Fair	Good	Excellent	Unknown
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What was the mother's age at child's birth? _____

How was the mother's diet during pregnancy?

Poor	Fair	Good	Excellent	Unknown
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Did the mother receive prenatal medical care? Y N Unknown

Did the mother experience any of the following during the pregnancy:

<input type="checkbox"/> Bleeding	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Physical or emotional trauma	<input type="checkbox"/> Other

Name: _____

Date: _____

Number of pregnancies? _____

Number of births? _____

Did the mother use any of the following during the pregnancy?

Tobacco Alcohol Recreational drugs:

Prescription medications:

Over the counter medications:

Supplements:

Other:

Lifestyle during pregnancy: Exercise Exposure to chemicals

Interventions used: Ultrasound Amniocentesis Other: _____

Birth history

Term length: Full Premature: _____ wks Late: _____ wks

Length of labor: _____ Weight at birth: _____

Any complications?

Was the birth: Vaginal/C-section Induced Forceps Anesthesia used Epidural

Did the child experience any of the following at or shortly after birth?

Jaundice Rashes Seizures Birth injuries

Birth defects

Other

Diet

How was your infant fed?

Breast fed. How long? _____ Formula. Milk/Soy/Other: _____ Other: _____

When were the solid foods introduced? _____

What foods were introduced before 6 months? (Please list approximate month as well.)

What foods were introduced between 6-12 months?

Did your child ever experience colic? Y N How severe? Mild Moderate Severe

Does your child have any allergies or intolerances? Please list.

Name: _____

Date: _____

Does your child have any dietary restrictions (religious, vegetarian/vegan, etc.)

Describe a typical day's diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages (and total quantity) _____

Health and Development

How was your child's health in the first year? Poor Fair Good Excellent Unknown

At what age did your child first:

Sit up _____ Crawl _____ Walk _____ Talk _____

Describe your child's sleep pattern: _____

How would you describe your child's temperament: _____

How would you describe your child's behavior and performance at school: _____

What social activities does your child like to do: _____

Family History

Please indicate if a close relative (parent, sibling) has had any of the following?

Condition	Who?	Condition	Who?
Allergies		Diabetes	
Birth defects		Kidney disease	
Asthma		Tuberculosis	
Juvenile arthritis		Cancer	
Other:			

I do not know the family medical history

Do either of the parents have a chronic illness? Y N If yes, please describe: _____

Childhood illnesses: Measles Rubella Roseola Chicken pox Mumps

Number of ear infections: _____ Other: _____

Name: _____

Date: _____

How much television does your child watch? _____ Hrs a day/week

How often does your child read (not for school), or how often does someone read to your child?

Daily Several times a week Weekly Less than a weekly

Does anyone in the child's household smoke? Y N

Are there animals in the home? Y N

How is the child's home heated? _____

Do you know of any toxins or other hazards the child is regularly exposed to (home, other's work, hobbies, etc.). Please describe.

How would you describe the emotional climate of the child's home?

Review of systems

General: Any weight changes? Please describe. _____
Any fatigue, weakness, fever? _____

Skin: rashes lumps itching dryness color change changes in hair or nails
 other _____

Head: headaches head injury dizziness lightheadedness

Eyes: glasses or contact lenses pain redness dryness discharge impaired vision
 other _____

Ears: infection pain discharge impaired hearing
 other _____

Nose and Sinuses: infection pain discharge nose bleeds
 other _____

Mouth and Throat: condition of teeth and gums pain redness dryness discharge hoarseness
 other _____

Neck: lumps goiter pain stiffness

Respiratory: cough sputum pain frequent infections

Cardiac: developmental abnormalities rheumatic fever murmurs chest pain

Name: _____

Date: _____

Gastrointestinal: appetite pain bowel habits indigestion vomiting hepatitis
Please elaborate on any of these symptoms and list ones that were not mentioned:

Urinary: urinary incontinence urgency pain stones

Is there anything that you feel is important that has not been covered?

Richard Dodd B.Sc., ND

Name: _____

Date: _____

INFORMED CONSENT

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopaths assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

Naturopathic medicine uses a variety of approaches. The main modalities used by Naturopaths are: diet and nutritional supplements, botanical medicine, homeopathy, traditional Chinese medicine and acupuncture, hydrotherapy, physical medicine, lifestyle counseling and intravenous therapy.

Individual diets and nutritional supplements are recommended to address deficiencies, treat diseases and promote health. The benefits include increased energy, increased gastrointestinal function, improved immunity and general well being.

Botanical medicine is a plant based medicine using herbals teas, tinctures, capsules and other forms of herbal preparations to assist in the recovery from injury and disease. Herbal preparations are used in the treatment as well as prevention of diseases.

Homeopathy is a form of medicine based on the Laws of Similars – that is the use of tiny doses of the very thing that causes symptoms in healthy people. These minute doses of plant, animal or mineral origins are used to stimulate the body's ability to heal itself. Homeopathy is a powerful tool and effects healing on a physical and emotional level.

Chinese medicine includes acupuncture, as well as the use of botanical formulas and dietary changes to eliminate disease and balance body functions. Acupuncture refers to the insertion of sterilized needles through the skin into underlying tissues at specific points on the surface of the body. Sometimes moxa (a compressed herb in the form of a stick) is burned over an acupuncture point to help relieve symptoms. Botanical formulas may be given in the form of pills, tinctures or decoctions (strong teas) to be taken internally or used externally as a wash. Herbal formulas may include shell, mineral and animal materials as well as plants. Dietary advice is based on traditional Chinese medical theory.

Physical medicine refers to the use of hands-on techniques such as soft tissue and spinal manipulation, as well as various types of electrical stimulation and therapeutic ultrasound for the purpose of treating musculoskeletal and neurological problems.

Intravenous therapy refers to injection of vitamins, minerals, specific amino acids and botanical extracts into the vein. This therapy ensures 100% absorption rate and allows high dosage administration without intestinal irritation.

The Naturopathic Doctor will take a thorough case history, do a screening physical examination, including a breast exam and urine sample analysis. If your case requires, the physical may include more specific examinations such as gynecological, rectal, prostate or genital exams.

Even the gentlest therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children, or those with multiple medications. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important therefore that you inform your Naturopathic Doctor immediately of any disease process that you are suffering from, if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding; please advise your ND immediately.

Name: _____

Date: _____

There is some slight health risks to treatment by Naturopathic Medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions (anaphylaxis) to supplements, injectables or herbs
- Inflammation of the vein used for injection, phlebitis
- Pain, bruising or injury from injections or acupuncture
- Fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa
- Muscle strains and sprains, disc injures from spinal manipulation

With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for (please list exceptions below):

I, the undersigned, do hereby acknowledge that I have been informed of and understand the recommended therapeutic and diagnostic procedures and have discussed to my satisfaction this and any requests for related information with the Naturopathic Doctor and/or with her office or clinical assistant(s). I further acknowledge and confirm that I have been informed of and understand the therapeutic and diagnostic procedures with respect to the financial costs, expected benefits, potential risks and side effects; the likely consequences of not having/following the therapeutic and diagnostic procedure(s), and what alternative course(s) of action are available to me.

As a result, I so hereby voluntarily consent my informed consent for the recommended therapeutic and diagnostic procedure(s) as specified above. I also understand that I may change the status of my voluntary informed consent at any time.

Patient Name: (Please print): _____

Signature of Patient or Guardian: _____

Date: _____

Signature of ND: _____

Richard A. Dodd B.Sc., ND

Name: _____

Date: _____

DIET DIARY

Please complete this diet report five days prior to your first appointment. Be sure to list all food and beverages consumed each day, indicating type of grains and breads and whether foods are raw or cooked, and how they were cooked. (For example, cod-poached, zucchini-steamed, raw salad-romaine lettuce, cabbage, peppers and cauliflower.)

DAY 1

Breakfast
Lunch
Dinner

DAY 2

Breakfast
Lunch
Dinner

Richard Dodd B.Sc., ND

Name: _____ Date: _____

DAY 3

Breakfast
Lunch
Dinner

DAY 4

Breakfast
Lunch
Dinner

DAY 5

Breakfast
Lunch
Dinner

**Privacy of Information Consent Form
For Collection, Use & Disclosure of Personal Information**

Ensuring the privacy of your personal information is an essential part of the quality care The Natural Path provides. We understand the importance of protecting your personal information & are committed to collecting, using & disclosing your personal information responsibly. We also try to be open and transparent about the way we handle your information.

Mary Vercillo is the Privacy Information Officer at The Natural Path.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. The staff are trained in the appropriate use and protection of your information.

In this consent form we have outlined what our office is doing to ensure this:

- only necessary information is collected about you;
- we only share your information with your consent;
- storage, retention & destruction of your personal information complies with existing legislation & privacy protocols;
- we comply with the privacy legislation of standards within our regulatory body and the law.

Do not hesitate to discuss our policies with me or any other member of our office staff. Please be assured that every staff member in our office is committed to ensuring you receive the best possible care.

How The Natural Path Collects, Uses & Discloses Patient's Personal Information

Our office understands the importance of protecting your personal information, we have outlined below how our office is using & disclosing your information. The Natural Path will collect, use & disclose information about you for the following purposes:

- to deliver safe & efficient patient care
- to ensure continuous high quality health care service
- to assess your health needs
- to advise you of treatment options
- to establish & maintain communication
- to communicate with other health care providers, including specialists & referring doctors
- to allow us to effectively follow-up for treatment, care & billing
- for teaching & demonstrating, on an anonymous basis
- to comply with agreements/undertakings entered into voluntarily by members of a governing body, including delivery and/or review of patients' charts and records in a timely fashion for regulatory and monitoring purposes

To comply with legal and regulatory requirements according to provisions of the Regulated Health Professions Act.

Please initial this page: _____

- to allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale
- to deliver your charts and records to the office's insurance carrier to enable our insurance company to assess liability and quantify damages, if any
- to prepare materials for the Health Professions Appeal and Review Board (HPARB)
- to invoice for goods & services
- to collect unpaid accounts
- to assist this office to comply with all regulatory requirements
- to comply with the law

By signing the Privacy Information Consent Form, you have agreed that you have given your consent to the collection, use and/or disclosure of your personal information for the purposes listed above. If a new purpose arises for the use of your personal information, we will seek your approval beforehand.

Your information may be assessed by regulatory authorities, under the terms of the Regulated Health Professions Act (RHPA) and for the defense of a legal issue.

The Natural Path will not under any circumstances supply your insurer with your confidential medical history. In the event of this request, we will forward the information directly to you for review, and your specific consent. When unusual requests are received, we will contact you for permission to release such information.

You may withdraw your consent for use and/or disclosure of your personal information at any time.

Patient Consent

I have reviewed the above information which explains how The Natural Path will use my personal information and the steps it will take to protect it.

I know that The Natural Path has a privacy code, which I can ask to review at any time.

I agree that The Natural Path can collect, use & disclose personal information about me _____ as set out in the Privacy Information Consent Form.

(Patient's Name)

Signature: _____

Date: _____

Witness: _____